SimonMed
See Tomorrow Today

Arrival Time: _____ MRN: _____

Patient Information – PLEASE PRINT

Patient Name (last name, first name): _____ ☐ Male ☐ Female

Date of Birth: _____ Social Security Number *(optional)*: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home #: (_____)_____ Cell #: (_____)_____ E-mail: _____

Emergency Contact: _____ Emergency Contact #: _____

Medical History

Known Allergies: _____

Current Medications: _____

FEMALE Patients Only: Is there a possibility you may be pregnant? ☐ YES ☐ NO Date of LMP: _____

Insurance / Workers Comp Information / Guarantor

Primary Ins/Work Comp: _____ Secondary Insurance: _____ Date of Injury: _____

Insured (Insurance): _____ Insured DOB: _____ Group# _____ Member ID# _____

Guarantor (Financially Responsible): _____ Guar. DOB: _____ Relation to Patient: _____ Cell #: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Patient's Authorized Representative

Please indicate with a YES or NO any authorized representative to whom we may release protected health information to, including any reports/films, insurance and or financial information. **If you are a parent or legal guardian, or have power of attorney over the patient, please list yourself below.*

Name: _____ Relationship: _____ Phone #: _____ ☐ YES ☐ NO

Telephone Consumer Protection Act Notice & Other Communication

→ INITIALS: _____

In order to service your account or collect any amounts I may owe, SimonMed or its agents may contact me by telephone at any telephone number associated with my account, including without limitation wireless or cell phone numbers, which could result in a charge to me. You may also contact me using pre-recorded/artificial voice messages and/or through the use of automatic dialing devices. Additionally, I authorize the use of text messages and direct mail for appointment information and SimonMed promotions only.

Payment Policy

Please review our Payment Policy, should you have any questions, we may discuss prior to your exam. **Insurance**: We participate in most insurance plans, including Medicare. If you do not have insurance or are not insured by a plan we are contracted with, payment in full is due at the time services are provided unless prior arrangements have been made and agreed to in advance. **Proof of Insurance/Referral Forms**: We may require that you provide us with a copy of your driver's license and valid insurance card to provide proof of insurance. If we are not provided with the correct information, you may be held responsible for payment. If you do not have your insurance card, you will be responsible for payment at the time of service. Once we obtain your insurance information, we will bill the insurance company and refund any overpayments once the claim has been paid by your insurance plan. Inform us of any insurance changes made after this signed agreement/date of service. Insurance carriers have specific timely filing guidelines and pre-authorization requirements for certain services. If revised insurance information is not provided to us within insurances' timely filing limits, you will be required to pay for services in full. If prior authorization was required for services already received and your claim is denied for lack of authorization, you will be required to pay for services in full. **Co-Payments, Deductibles, & Coinsurance**: You agree to pay all co-payments, deductibles, and co-insurance at the time your exams are performed as required by your insurance plan. A time of service payment is an estimate of the amount due. The final amount due cannot be calculated until the claim is processed by your insurance company. Additionally, the estimate of the amount due at time of service may change over time due to deductible charges processed for other medical services rendered. **Non-Covered Services**: In some instances, the services you receive may not be covered or considered medically necessary by Medicare or other insurance plans. In these instances, you will be required to pay for these services in full at the time of your exam. Medicare patients may be required to complete a separate Advance Beneficiary Notice form in order for services to be rendered. **Assignment**: By signing this form, you agree to assign all insurance benefits to SimonMed Imaging for services performed and authorize SimonMed Imaging to submit a claim to Medicare or my insurance plan. We will submit your claim(s) to your insurance plan and will provide you with reasonable assistance to get the insurance plan to pay the claim(s). **Collections**: Once an account is placed in collection status, all future services must be paid in full at the time of service. There is a $25.00 fee for any returned checks. Patient payment policies may not be applicable in certain cases, including but not limited to workers compensation cases.

Notice of Privacy Practices & Patient Rights Acknowledgement

By my signature, I acknowledge receipt of the provider's Notice of Privacy Practices (HIPAA) and the provider's Patient Rights and have been given the opportunity to read them.

Release of / Request for Information Authorization

SimonMed Imaging may disclose all or part of the patient's medical and/or financial record to your insurance plan of benefit eligibility, to referring physicians, and to other healthcare providers responsible for providing continued patient care. We may request health information relating to imaging studies performed by SimonMed. This may include, but is not limited to, previous films, symptoms/history, laboratory results, pathology reports, etc. I understand that the above listed Patient's Authorized Representative will remain valid for 1 year (or until my next appointment) whichever is sooner. SimonMed Imaging may charge a fee of up to $25.00 for each set of requested films.

General Consent and Right to Refuse Treatment

General Consent to Treatment: By signing below, I (or my authorized representative on my behalf) authorize SimonMed Imaging and their staff to conduct any diagnostic examinations, tests and procedures and to provide any medications, treatment to effectively assess and maintain my health, and to assess, diagnose and treat my illness or injuries. I understand that it is the responsibility of my individual treating healthcare provider(s) to explain to me the reason(s) for any particular diagnostic examination, test or procedure, the available treatment options and the common risks and benefits associated with these options as well as alternative courses of treatment. **Right to Refuse Treatment:** In giving my general consent to treatment, I understand that I retain the right to refuse any particular examination, test, procedure, treatment or medication recommended or deemed medically necessary as prescribed by my referring physician. I also understand that the practice of medicine is not an exact science and that no guarantees have been made to me as the results of my evaluation and/or treatment.

By signing below, I am stating that I understand and agree with the above policies and acknowledgement.

Patient Signature: _____ Date: _____

Patient Signature: _____ Date: _____

Patient Signature: _____ Date: _____